HEALTH EXAMINATION AND IMMUNIZATION/SCREENING REQUIREMENT FORM

AFTER contract award, but prior to performing services, the contract health care worker shall have this form completed by a licensed medical practitioner.
All health care workers providing services under this contract must meet all the requirements specified under the "Required Documentation" column of this form.*

COPIES OF IgG TITER LABORATORY RESULTS MUST BE ATTACHED TO THIS FORM

IMMUNIZATION/ SCREENING	REQUIRED DOCUMENTATION	DATES and RESULTS (to be completed by examining licensed practitioner)	
VARICELLA (CHICKENPOX)	Physician documented history of varicella (chickenpox/herpes zoster) disease, **OR**	Hx:	
	2-dose vaccine series, **OR**	Dates of Shots: 1. 2.	
	Positive IgG titer	Titer/Date:	
MEASLES/ MUMPS/ RUBELLA (MMR)	MMR live virus 2-dose vaccine, **OR**	Dates of Shots: 1. 2.	
	Positive IgG titer for each of Measles, Mumps, and Rubella	Titer/Date:	
HEPATITIS B	HBV 3-dose vaccine series **AND** positive IgG titer, **OR**	Dates of Shots: 1. 2. 3. Titer/Date:	Dates of Repeat Shots: 1. 2. 3. Titer/Date: Counseling provided:
	HBV 3-dose vaccine series with negative titer **AND** repeat 3-dose HBV series with repeat titer **AND** in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response, **OR**		
	Written declination form signed and submitted		
TETANUS/ DIPHTHERIA/ PERTUSSIS	Tetanus/Diphtheria/Pertussis (Tdap) within the preceding 10 years.	Date of Tdap:	
TUBERCULOSIS (Determine baseline then as per activity risk assessment)	Two-step Tuberculin Skin Test (TST), **OR**	2-Step TST dates: 1st test: 1st result: 2nd test: 2nd result:	Date/result of last eval:
	An evaluation if known PPD reactor (within the past year for a new hire)		
LATEX	Latex sensitivity screening questionnaire administered	Date of evaluation: Results: Sensitive Not sensitive	
	If latex sensitivity suspected, follow with appropriate allergy testing	Date of test: Results:	
SEASONAL INFLUENZA	An annual seasonal influenza vaccination	Date of Current Seasonal Flu Vaccination:	

_____ [Name of Contract Health Care Worker] has presented for a physical examination. He/She is applying for the position of _____[Please enter job title].

He/She was examined on _____ [date] and found to be in good health, meeting the immunization/ screening required above, and is free of any medical condition or infectious disease that may prevent his/her ability to perform services for the position described above. YES NO [Please circle either YES or NO.]

Provider's Signature: _____ Provider's Name: _____

Facility/Address: _____

Phone Number: _____ Date: _____

*The facility will identify any **incumbent** HCWs who are not required to complete this documentation.

Version of 22 June 2010